TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT METROPLEX

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-17-0198-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
SEPTEMBER 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was received and denied by the carrier for timely filing. We appealed this decision as we provided proof that we attempted contact to see if claim was on file within the 95 days allowed by the state. There was no response back from the carrier. Per the Broadspire representative their email system was not working at the time and were at that point advised to re-send the claim to the carriers email. At this time the there was an internal reconsideration made received 5/17/16 and is still processing when the state allows 60 days on appeals. We do not have an EOB to provide with this dispute."

Amount in Dispute: $5,425.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill remains denied due to untimely filing."

Response Submitted By: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2015	Ambulatory Surgical Care Services CPT Code 29823-RT	$5,425.92	$0.00
	Ambulatory Surgical Care Services CPT Code 29826-RT	$0.00	$0.00
TOTAL		$5,425.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.

3. The services in dispute were reduced / denied by the respondent with the following reason code:
   - D00-Based on further review, no additional allowance is warranted.
   - D10-The time limit for filing has expired.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "D10-The time limit for filing has expired."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The requestor states "We appealed this decision as we provided proof that we attempted contact to see if claim was on file within the 95 days allowed by the state. There was no response back from the carrier. Per the Broadspire representative their email system was not working at the time and were at that point advised to re-send the claim to the carriers email. At this time the there was an internal reconsideration made received 5/17/16." In support of the position, the requestor submitted the *Insurance Billing History* report that indicates Broadspire WC was billed on December 4, 2015 via electronic mail, and Paper on January 5, 2016. A fax confirmation, personal delivery or electronic transmission or a postmark letter was not submitted to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/21/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.